city**benefit**
new**directions**

Medicare Supplement Plan

2005-2006
Plan Year

Great-West[SM]
HEALTHCARE

Table of Contents

Welcome

At the City of Long Beach, we take pride in offering our retirees a choice of two quality health care plans. These plans are reviewed and modified annually to ensure that your health care needs continue to be met at a cost that is consistent with the City's financial goals. The City's goal is to continue to provide you with quality coverage options that promote your health and wellness.

This summary describes important plan features for the City's Medicare Supplement Plan, a self-insured group health plan administered by the Great-West Healthcare and Annuity Insurance Company. While every effort has been made to accurately highlight key plan provisions, it's important to note that this summary does not contain complete plan details. The plan is governed by legal plan documents. If a question arises as to matters not addressed in this summary, or if there is any conflict between statements in this summary and the legal plan documents, the terms of the plan documents or insurance contracts shall govern.

From time to time, the City may give you other written materials on your plan. Be sure to keep these materials with this booklet so that your plan information remains current and in one place

Eligibility & Effective Dates

When You Become Covered

If you are a new retiree, you will become eligible to join the Medicare Supplement Plan on the date you are:

- Retired from the City of Long Beach, and
- Eligible for both Part A (Hospital) and Part B (Medical) of Medicare.

Eligible Dependents

Your eligible dependents include:

- Your legal spouse.
- Your unmarried dependent children from birth to age 19. This includes natural children, stepchildren, and adopted children. Foster children, when there are court orders for legal custody and they are placed in a Certified Foster Home, are also included.
- Your unmarried, dependent child up to age 26 if a full-time student at a state recognized educational institution.
- Your dependent child who on the day immediately preceding the effective date of your coverage under this plan was covered under one of the following plans sponsored by the City of Long Beach:
  - Group Plan Number 50703, underwritten by the Great-West Healthcare and, Annuity Insurance Company, or
  - PacifiCare
- Your unmarried, dependent child who is totally incapacitated due to mental retardation or physical handicap before reaching the age at which coverage would otherwise end. Eligibility for the child will be extended for as long as you are covered by the plan, the disability continues, and the child continues to qualify for coverage in all respects other than age. You will be required, within six months prior to the date that coverage would otherwise terminate, to submit a current physician's statement certifying the disability. If this proof is not submitted within 60 days of the request, the child's coverage under this policy will terminate. You may be required to submit additional statements from time to time which certifies the continuing disability.

  Dependent children must rely on a retiree for a least 50% of their principal support and be eligible to be claimed on the retiree's annual federal tax return.

Change in Family Status

If you wish to add a new dependent, you must notify the City of Long Beach and sign the proper form within 31 days after your dependent becomes eligible or when you no longer have any eligible dependents.

When Participation Ends

Unless otherwise specified in this booklet, your coverage ceases:

- The last day of a period for which you fail to make any required contributions/payments for coverage
- The day the plan ends

If you were eligible for a pension from the Public Employee Retirement System or the Firemen or Policemen pension plans for their coverage under the Medicare Supplement, upon your death your eligible dependents may continue their coverage until the earliest of the following dates:

- The last day of a period for which you fail to make any required contributions/payments for coverage
- The date of death of the surviving spouse
- With respect to a dependent child, the date on which such child ceases to qualify as a dependent
- The day the plan ends

This provision is subject to all other provisions of the plan. Payment of the entire required plan contribution/cost must be made by the surviving dependents to the City of Long Beach.

Continuation of Medicare Supplement Coverage

If you or one of your dependents are totally disabled when your coverage under the Medicare Supplement Benefit terminates, and you have incurred expenses for such disability which would have been paid had your coverage continued, benefit payments will continue until the earliest of the following:

- The date the disability ends
- The date on which you have received maximum benefits
- The date 3 months from the date your coverage terminates
- The date on which you become covered under any replacement plan issued to the City of Long Beach by another carrier
- The date on which you become covered under any other group insurance/benefits plan

Key Terms

To make the most of the benefits described in this booklet, it is important that you understand the key terms defined below. Please note that the terms are listed alphabetically.

Ambulatory Surgical Center

A public or private institution that is:

- Established, equipped and operated primarily as a facility for performance of surgical procedures and meets the following requirements:

  (a) is operated under the supervision of a staff of doctors, maintains adequate medical records and provides for periodic review of the facility and its operation by a Utilization and/or Tissue Committee composed of doctors other than those owning or supervising the facility;

  (b) permits a surgical procedure to be performed only by a doctor privileged to perform such a procedure in a hospital in its area and requires that a licensed anesthesiologist administer the anesthetics and be present during the surgical procedure, unless only local infiltration anesthetics are used;

  (c) provides no overnight accommodations for patients, has at least two operating rooms, one post-anesthesia recovery room and full-time services of registered nurses (RN) in all operating and post-anesthesia recovery rooms;

  (d) is equipped to perform diagnostic X-ray and laboratory examinations and has the necessary equipment and trained personnel to handle foreseeable emergencies, including a defibrillator for cardiac arrest, a tracheotomy set for airway obstruction, and a blood bank or other supply for hemorrhaging;

  (e) maintains written agreements with hospitals in its area for immediate acceptance of patients who develop complications or require postoperative confinement; or

- Licensed as an ambulatory surgical center by the state in which the center is located.

Benefit Period

A benefit period is a limited number of days, determined by Medicare, for which Medicare will help you pay for Medicare eligible expenses. A benefit period begins the day you are admitted to a hospital. It ends when you have been out of a hospital or Skilled Nursing Facility for 60 straight days. It also ends if you stay in a Skilled Nursing Facility, without receiving skilled nursing care for 60 straight days. Once you have ended one benefit period a new benefit period begins.

Blood Deductible

The first 3 pints of whole blood, units of packed red blood cells, or blood components for which you are responsible.

Brand Non-Preferred Prescription Drug

Brand Non-Preferred Prescription Drugs are those made by the original manufacturer of the drug, but that do not appear on the plan's formulary.

Brand Preferred Prescription Drug

A Brand Preferred Prescription Drug is a product made by the original manufacturer of the drug that is listed on the plan's formulary. When a physician requests that a prescription be "filled with the brand preferred," it means that the request is for the product made by the original manufacturer.

Daily Coinsurance

The amounts you must pay, as determined by Medicare, for each day of care.

Generic Name

A Generic Name is the official drug name, as determined by the United States Adopted Names (USAN) and accepted by the Federal Drug Administration (FDA), for that drug regardless of its manufacturer. Each drug has only one generic name.

Generic Prescription Drug

A Generic Prescription Drug refers to the product manufactured by a drug company other than the original manufacturer of the drug, meeting all FDA bioavailability standards. California law allows pharmacists filling a prescription order for a drug product prescribed by a brand name to select a product of the same generic drug type unless the prescriber personally indicates "do not substitute," or if the member specifically requests a brand name product. This is the process known as "filled with the generic."

Hospital

A hospital is a:

- Legally operated institution providing inpatient care and treatment through medical, diagnostic and major surgical facilities on its premises, under supervision of a staff of doctors, and with 24-hour-a-day nursing services;
- Medical facility accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or
- Christian Science Sanatorium, or other institution approved by the Department of Care of the Mother Church, The First Church of Christ, Scientist in Boston, Massachusetts.

The term "Hospital" does not include a nursing home, nor an institution or part of one which (a) is used mainly as a facility for convalescence, nursing, rest, or the aged, (b) furnishes primarily domiciliary or custodial care, including training in daily living routines.

Medicare Allowable

The amount determined by Medicare to be medically necessary and a portion of which is covered by Medicare.

Physician

A licensed practitioner of the healing arts acting within the scope of his license. Such term also includes the personal services of a Christian Science Practitioner authorized by the Mother Church, The First Church of Christ, Scientist in Boston, Massachusetts.

PPO Network Hospital

(Hospital that Accepts Medicare)

Any facility that has been selected by the insurance carrier and that accepts Medicare and participates in the plan's national network. A listing of network hospitals may be viewed online at www.mygreatwest.com. To find out if your hospital participates in the network, you may also call the Great-West Healthcare Benefit Payment Office at (800) 766-3206.

PPO Physician

(Physician Who Accepts Medicare)

Any physician selected by the insurance carrier who accepts Medicare and participates in the plan's national network. These providers have been precertified and credentialed. A listing of network providers may be viewed online at www.mygreatwest.com. To find out if your doctor participates in the network, you may also call the Great-West Healthcare Benefit Payment Office at (800) 766-3206.

Reserve Days

A Medicare lifetime maximum of days which can be used in the event your confinement in a facility exceeds the Medicare benefit period.

How the City's Medicare Supplement Plan Works

When you retire from the City and become eligible for Medicare benefits (at age 65 or above), the City's Medicare Supplement Plan will provide coverage in addition to your Medicare coverage. However, you must be enrolled in both Part A and Part B of Medicare and have services provided within the United States.

The City's Medicare Supplement Plan offers an extensive preferred provider network that includes physicians, hospitals and other types of health care providers. As long as you use providers who accept Medicare and participate in the network, your care will be covered at the highest benefit level. Coverage is also available through licensed providers outside the network; however, reduced benefits apply.

If you choose to seek care from a network provider who accepts Medicare, unless otherwise specified, the Medicare Supplement Plan will provide the following benefits:

When you use providers who accept Medicare, the plan pays:

- The Medicare deductible, and
- 100% of all Covered Expenses not payable by Medicare.

If, on the other hand, you receive treatment (including any emergency) from a non-Medicare provider, unless otherwise specified, the Medicare Supplement Plan will provide the following benefits:

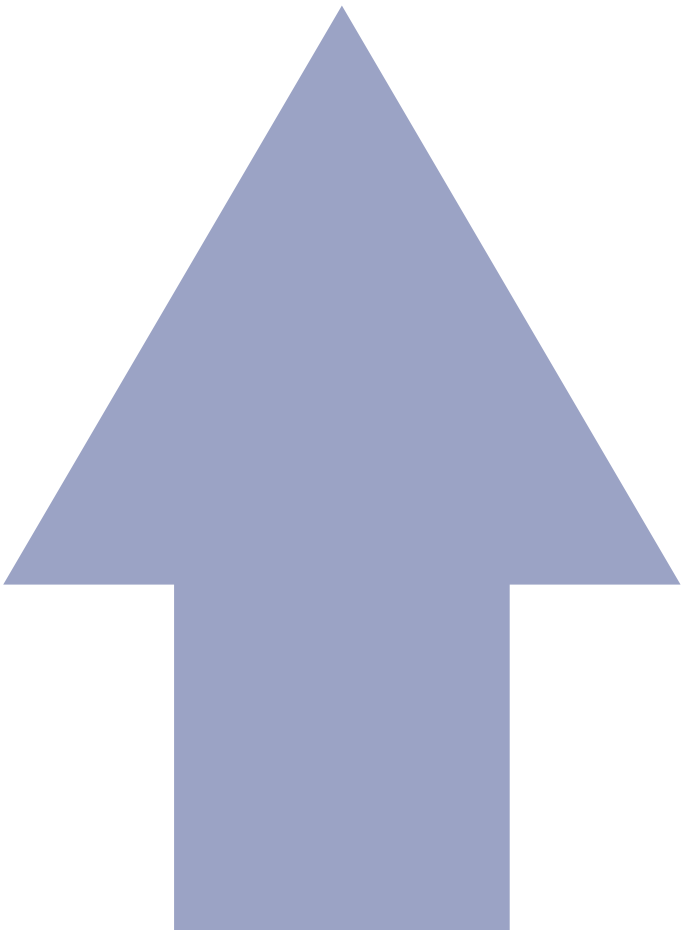
When you use non-Medicare providers, the plan pays:

- The Medicare deductible, and
- An amount up to the Medicare Allowable Expense Limit not payable by Medicare.

Important: Please note that if services are not covered (that is, considered eligible expenses by Medicare), this Medicare Supplement Plan will pay nothing unless otherwise stated in this booklet.

If You Have Questions

For more information, call the Great-West Healthcare Benefit Payment Office at (800) 766-3206, or Member Services at the number listed on your ID card. The Great-West Member Services team will answer your questions regarding claims, networks and other concerns.



Comparison of Benefits

Benefits are payable on a calendar year basis.

Coverage Basis

	Medicare Providers	Non-Medicare Providers
Coverage basis for all benefits provided under the plan	All Medicare eligible expenses not payable by Medicare will be paid up to 100%	Medicare Allowable Expenses only
Part A - Hospital Expense (Covered Services in each benefit period)		
1st through 60th day	All Medicare eligible expenses not payable by Medicare will be paid up to 100%	Medicare hospital deductible paid up to 100%
61st through 90th day	All Medicare eligible expenses not payable by Medicare will be paid up to 100%	Medicare daily coinsurance paid up to 100%
91st through 150th day (considered Reserve Days)	All Medicare eligible expenses not payable by Medicare will be paid up to 100%	Medicare daily coinsurance paid at 100% up to the 60 day Medicare lifetime maximum
151st day and thereafter	NO COVERAGE	NO COVERAGE
Blood	All Medicare eligible expenses not payable by Medicare will be paid up to 100%	Medicare Blood Deductible paid up to 100%
Hospice Care	All Covered Expenses not payable by Medicare will be paid up to 100%	Medicare pays nearly the entire bill for Medicare allowable expenses, less copayments. The plan will pay the Medicare copayments up to the Medicare Allowable Expense Limit.
Psychiatric Hospital Coverage (for confinement at a Medicare-participating psychiatric hospital	All Medicare eligible expenses not payable by Medicare will be paid up to 100%	Medicare Deductible and any applicable coinsurance paid up to 100%
Skilled Nursing Facility	All Covered Expenses not payable by Medicare will be paid up to 100% up to the plan limit of 100 days	Medicare pays 100% of the Medicare Allowable Expense for the 1st through the 20th day. For the 21st through 100th day, Medicare pays 100% of the day charges, less a daily coinsurance. The plan will pay the daily coinsurance up to the Medicare Allowable Expense Limit. No plan benefit is payable after the 100th day.
PART B - MEDICAL EXPENSES (Covered Services per Calendar Year)		
Coverage basis for non-hospital related charges provided under this plan	All Medicare eligible expenses not payable by Medicare will be paid up to 100%	Medicare pays 80% of the Medicare Allowable Expense. The plan will pay the Medicare Deductible and the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit.
Blood	All Medicare eligible expenses not payable by Medicare will be paid up to 100%	The plan will pay the Blood Deductible, Medicare Deductible and the remaining 20% up to the Medicare Allowable Expense Limit.

	Medicare Providers	Non-Medicare Providers
Chiropractic	All Covered Expenses not payable by Medicare will be paid up to 100%	Medicare pays 80% of the Medicare Allowable Expense. The plan will pay the Medicare Deductible and the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit.
Durable Medical Equipment (See page 8 for a list of common purchases of equipment)	All Covered Expenses not payable by Medicare will be paid up to 100% if rented or purchased from a contracted facility	After $50 calendar year deductible, Medicare pays 80% of the Medicare Allowable Expense. The plan will pay the Medicare Deductible and the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit.
Ophthalmological Services (limited benefits, see page 9)	Medicare pays 80% of the Medicare Allowable Expense. The plan will pay the Medicare Deductible and the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit.	
Outpatient Psychiatric Care	All Medicare eligible expenses not payable by Medicare will be paid up to 100%	Medicare pays 50% of the Medicare Allowable Expense. The plan will pay the Medicare Deductible and the remaining 50% up to the Medicare Allowable Expense Limit.
Podiatry	All Covered Expenses not payable by Medicare will be paid up to 100%	Medicare pays 80% of the Medicare Allowable Expense. The plan will pay the Medicare Deductible and the remaining 20% of covered expenses up to the Medicare Expense Limit.

Other Medicare Eligible Expenses

When you use Medicare providers, your Medicare Supplement Plan pays the Medicare deductible and 100% of Allowable Expenses not paid by Medicare. When you use non-Medicare providers, the City's Medicare Supplement Plan pays for the Medicare deductible and 20% of the following Medicare Allowable Expenses. Medicare pays the remaining 80%.

The following services are covered:

- Ambulance transportation
- Arm, leg, back and neck braces
- Artificial limbs and eyes
- Blood, after the first three pints
- Bone mass measurement
- Breast prostheses following a mastectomy
- Colorectal cancer screening
- Diabetic supplies
- Durable medical equipment, including wheelchairs, walkers, hospital beds and oxygen equipment prescribed by a doctor for home use
- Flu, pneumonia and hepatitis B shots
- Home health care, if you do not have Part A of Medicare
- Kidney dialysis and kidney transplants. Under limited circumstances, heart and liver transplants in a Medicare-approved facility
- Mammograms to screen for breast cancer
- Medical supplies and items such as ostomy bags, surgical dressings, splints and casts
- Outpatient hospital services
- Outpatient mental health services
- Pap smears for the detection of cervical cancer
- Physical and occupational therapy
- Services of certain specially-qualified practitioners who are not doctors
- Speech language pathology services
- X-rays and laboratory tests

For further information regarding covered expenses under Medicare, please contact Medicare directly.

Chiropractic (Spinal Adjustment Treatment)

When you receive spinal manipulation service for subluxation of the spine which can be proven by an x-ray, the plan pays the Medicare deductible and 20% of Medicare Allowable Expenses. Medicare pays 80% of the Allowable Expense. For a contracted network chiropractor in your area, see your directory or call (800) 678-9133. Contracted providers have agreed to accept reduced fees for services which means you pay fewer dollars for health care services than you would using non-contracted providers.

Dentists' Services

Medicare Part B generally does not pay for care in connection with the treatment, filling, removal, or replacement of teeth; root canal therapy; surgery for impacted teeth; or other surgical procedures involving the teeth or structures directly supporting the teeth. However, Medicare does help pay for services of a dentist in certain cases when the medical problem is more extensive than the teeth or structures directly supporting them. (If you need to be hospitalized because of the severity of a dental procedure, Medicare Part A may pay for your inpatient hospital stay even if the dental care itself is not covered by Medicare.)

For Medicare allowable dental treatment, the City's Medicare Supplement Plan pays the Medicare deductible and 20% of the Medicare Allowable Expenses. Medicare pays 80% of the Allowable Expenses.

Durable Medical Equipment

If you rent or purchase Durable Medical Equipment (DME) from a Medicare contracted facility, you will be reimbursed 100% of covered and approved Medicare expenses. Please call (800) 766-3206 to find the contracted facility closest to you.

Listed below are the most common rentals and purchases of durable medical equipment. Please contact the Great-West Healthcare Benefit Payment Office at (800) 766-3206 to ensure that the equipment you are renting or purchasing is a covered expense.

- Apnea Monitor
- Asthma Flow Meter
- Bilirubin Light
- Blood Glucose Meter
- Breast Prosthesis
- Braces
- Colostomy supplies
- Commodes
- Crutches
- Diabetic supplies
- Hospital Beds
- Insulin supplies
- Walkers
- Wheelchairs

Ophthalmological Services

Neither Medicare nor the insurance carrier will pay for routine eye exams, and usually they will not pay for eyeglasses.

Medicare pays for specific Medicare-covered vision care, including the services of an ophthalmologist/optometrist if the optometrist is legally authorized to perform those services by the state in which he or she performs them. Specifically, Medicare will pay for cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery. Medicare will also pay for one pair of conventional eyeglasses or conventional contact lenses if necessary after cataract surgery with insertion of an intraocular lens.

For optometry services, the City's Medicare Supplement Plan pays the Medicare deductible and 20% of the Medicare Allowable Expenses. Medicare pays 80% of the Allowable Expenses.

Podiatry

For podiatry (treatment of feet), Medicare Part B helps pay for any covered services of a licensed podiatrist to treat injuries and diseases of the foot. Examples of common problems include ingrown toenails, hammer toe deformities and heel spurs.

Medicare generally does not pay for routine foot care such as cutting or removal of corns and calluses, trimming of nails and other hygienic care. But, Medicare does help pay for some routine foot care if you are being treated by a medical doctor for a medical condition affecting your legs or feet (such as diabetes or peripheral vascular disease) which requires that the routine care be performed by a podiatrist or by a doctor of medicine or osteopathy.

For podiatry treatment, the City's Medicare Supplement Plan pays the Medicare deductible and 20% of Medicare Allowable Expenses. Medicare pays 80% of the Allowable Expenses.

Additional Benefits Not Covered by Medicare

The City provides eligible retirees with the following additional benefits not covered by Medicare.

Hearing Aid

Covered expenses will be paid after the $50 plan year deductible at 80% coinsurance for an initial hearing aid or set of hearing aids, examinations and testing for the fitting of hearing aids, ear molds, and repair of hearing aids. The benefit maximum will not exceed $1,000 during any three year period (36 consecutive months). Contracted providers have agreed to accept reduced fees for their services which means you pay fewer dollars for health care services than you would using non-contracted providers.

Orthotics

Covered expenses will be paid after the $50 plan year deductible if they are prescribed by a physician or podiatrist, custom designed for the particular patient, considered effective treatment for the condition and required for all normal activity. The plan will pay 80% of the covered charges up to a $75 maximum every three years (36 consecutive months). Contracted providers have agreed to accept reduced fees for their services which means you pay fewer dollars for health care services than you would using non-contracted providers.

Registered Nursing Services

Expenses for private duty nursing by a Registered Nurse will be paid at 80% of the covered charges up to a lifetime maximum of $5,000, after the $50 calendar year deductible.

Prescription Drug Benefits

Overview

The City's Medicare Supplement Plan provides prescription drug coverage up to a calendar year paid maximum of $2,000. Benefits are provided through Express Scripts. The plan includes a mail order prescriptions program, as well as a Discount Program that extends your opportunity for prescription drug savings, even after you reach your $2,000 maximum.

About Medicare Part D

Medicare Part D is a voluntary program that provides prescription drug benefits to eligible retirees who enroll in the program. You do not have to enroll in a Medicare Part D prescription drug plan (PDP) to be eligible for prescription drug benefits through the City's Medicare Supplement Plan. However, if you do enroll in a Medicare Part D plan, you become eligible for supplemental prescription drug benefits through Medicare.

The City's Medicare Supplement Plan Rx Benefits

The City's prescription drug program for retirees is offered through Express Scripts, a nationwide network of over 50,000 pharmacies linked to an electronic claims system. All participating pharmacies have agreed to limit their charges to Express Scripts cardholders. Because these pharmacies have access to your coverage information, they know exactly how much you should pay for each prescription. Claims are processed electronically at the time of purchase, so there is no need for you to complete claim forms.

The Express Scripts program includes a formulary, which is a list of drugs that the plan covers. You may still receive benefits for prescription drugs that do not appear on the formulary, but your costs will be higher.

How the Program Works

To use this program:

- Present your ID card when purchasing drugs at any participating pharmacy
- Sign the claims voucher requested by the pharmacy
- Pay the pharmacy a copay of $10 for generic drugs; $25 for brand preferred; and $40 or 30% (whichever is higher) for brand non-preferred for each prescription or refill.

If You Don't Have Your Card with You

If you don't have your Express Scripts ID card with you when you use a participating pharmacy, the pharmacist may be able to verify your coverage by calling the Great-West Healthcare Benefit Payment Office at (800) 766-3206. If this is not possible, you must pay the full price for the prescription and file a claim to be reimbursed. If you choose an Express Scripts pharmacy, your reimbursement will be the same amount as if you had presented your card. Express Scripts will send this reimbursement directly to you.

If You Purchase a Prescription at a Non-Express Scripts Pharmacy

If you purchase drugs at a non-participating pharmacy, you must:

- Pay the full price of the prescription and file a claim for reimbursement.
- Ask the City of Long Beach Department of Human Resources staff for an Express Scripts prescription drug claim form.
- Complete the claim form, attach your prescription drug receipt, and mail these items to the address printed on the form.

Express Scripts will send the reimbursement directly to you. You will be reimbursed for the amount which would have been paid for the prescription drug had you used an Express Scripts pharmacy. If your pharmacy charges more for a prescription drug than an Express Scripts pharmacy, you will be responsible for the difference.

Covered Expenses

All prescriptions will be covered at 100% after a copayment requirement. Generic prescriptions will require a $10 copayment and brand preferred prescriptions determined medically necessary will require a $25 copayment. Brand non-preferred prescriptions will require a copay of $40 or 30%, whichever is higher. All prescriptions determined medically necessary by your physician will be filled for up to or part of a 30 DAY SUPPLY.

A brand name prescription REQUESTED when a generic is available or NOT determined medically necessary by your physician will require additional copayments. I**f you request a brand-name drug when there is a generic equivalent, you must either purchase the generic drug, or pay 100% of the difference between the brand-name price and the generic price, plus the copayment. The only exception to this rule is if your doctor writes "Dispense As Written," or "DAW," on your prescription, in which case the brand-name drug will be dispensed at the brand-preferred or brand non-preferred copayment (depending on the drug).**

Over the counter prescriptions (drugs which do not require a prescription to be purchased) such as vitamins or fluoride, are not considered to be eligible under the plan. Diet pills, including Meridia and Xenical are not covered even when they are prescribed by your PCP or a diet center.

Oral contraceptive prescription drugs are covered by the plan. Impotence dysfunctional drugs (i.e., Viagra) will be covered up to 10 pills per month (after you meet your deductible) when these steps are followed:

1. You must be examined by a urologist who determines the medical necessity of the drug.

2. The first and second prescription must be written by the urologist who will document the medical reason for the drug and after the first month will determine the effectiveness of the drug.

3. After the second prescription, your PCP may prescribe the drug, if medically necessary, for up to two years.

4. For continued use of impotence dysfunctional drugs after two years, you must go through the previous steps 1 – 3 again.

After You Reach Your $2,000 Maximum

To benefit from the Discount Program on prescriptions after you have met your annual $2,000 plan maximum, you must use the Express Scripts system. Simply present your health plan ID card to your Express Scripts pharmacist each time you purchase a prescription. Your pharmacist will manage the details from there.

Save Money with Generics

A generic drug is the chemical equivalent of a brand-name prescription drug. Generic drugs can cost up to 95% less than their brand-name counterparts, and that is their only significant difference. Generic and brand-name drugs are the same in that they are dispensed in the same dosage; taken in the same way; and packaged in the same unit strength. Generic prescriptions require only a $10 copayment, which is significantly less that the $25 copayment required for medically necessary brand preferred prescriptions.

Advantages of Mail Order

If you take maintenance medications for conditions such as high blood pressure, diabetes or asthma, you can save money by purchasing your prescriptions by Express Scripts Mail Order. When you purchase prescriptions through the mail, you pay twice the applicable copayment for three-times the supply (90 days rather than 30 days). You also get the convenience of home delivery.

Once you reach your $2,000 plan maximum, you remain eligible for the Discount Program on additional Mail Order prescriptions.

To maximize savings, start using the Mail Order program immediately, even before you reach your $2,000 plan maximum. With the discount, fewer dollars are applied to your plan maximum, so reaching your maximum will take longer.

You must ask your doctor in order to participate in the Mail Order program. Your doctor should write your maintenance medication prescription for up to a 90-day supply, with up to three refills. You can order refills by telephone or over the Internet. If you are not sure whether or not your prescription is available for Mail Order, or if you would like to find out if a generic equivalent is available, you may call Express Scripts at 1-888-377-9378, or visit their website at www.express-scripts.com.

All prescriptions will be covered at 100% after copayment requirements. Generic prescriptions will require a $10 copayment and brand preferred prescriptions determined medically necessary will require a $25 copayment. Brand non-preferred prescriptions will require a copay of $40 or 30%, whichever is higher. All prescriptions determined medically necessary by your physician will be filled for up to or part of a 90-DAY SUPPLY. A brand name prescription REQUESTED when a generic is available or NOT determined medically necessary by your physician will require additional copayments.

Coordination

If you are covered under another group benefit program, in order to ensure that coordination occurs, have your pharmacist give you a receipt for your prescription indicating the charge amount and the copay amount. Submit this receipt to the insurance carrier as you would any other claim. This will ensure that the Prescription Drug Covered Expense will be coordinated in the same way as any other Medical Covered Expense under this plan.

If You Enroll in a Medicare Part D Prescription Drug Plan

If you choose to enroll in a Medicare Part D Prescription Drug Plan (PDP) to receive supplemental prescription drug coverage, here's how benefits from the City's Medicare Supplement Plan will be coordinated with Medicare Part D benefits:

Effective January 1, 2006, provided you enroll in a Medicare PDP, the City's Medicare Supplement Plan will pay:

- 100% of all covered expenses not payable by Medicare (this includes deductibles and/or copays plus any coinsurance required under the chosen plan) up to the City's maximum annual prescription drug benefit of $2,000.
- You become eligible for additional catastrophic prescription drug benefits (at least 95% coverage) through Medicare part D after you satisfy the Medicare PDP's annual out-of-pocket limit (which cannot exceed $3,600).

Skilled Nursing Facility Expenses Following Hospitalization

The plan provides benefits for eligible expenses incurred during a Medicare covered Skilled Nursing Facility confinement. The confinement must start within 30 days after being confined for at least 3 days in a hospital. Medicare pays 100% of the first 20 days. The City's Medicare Supplement Plan pays the daily coinsurance amount not paid for by Medicare for days 21 through 100.

The eligible expenses are the nursing facility charges for the following services and supplies furnished while the patient is under continuous care of his/her doctor and requires 24-hour nursing care:

- Room, board and other services and supplies furnished by the facility for necessary care (other than personal items and professional services).
- The above expenses will be considered additional hospital bills and combined with the bills for the prior hospital confinement in determining the amount to be paid under the Major Medical Expense Insurance.
- A 100-day limit applies to all nursing facility care due to the same or related causes.

Hospice Care

Hospice care is a benefit for the terminally ill (life expectancy of 6 months or less as certified by the attending physician). Rather than the patient remaining in the hospital, when the hospital setting is no longer required, it is usually beneficial for all concerned to provide the appropriate services at home. Hospice care can consist of two types of benefits: those provided in a hospice care facility or in your home. Medicare pays 100% of the Allowable Expenses for hospice care. The City's Medicare Supplement Plan pays any copayments, not payable by Medicare, for Medicare Allowable Expenses for prescription drugs and inpatient respite care.

Inpatient respite care is intended to give temporary relief to the person or persons who regularly assist with home care.

Exclusions

The City's Medicare Supplement Plan does not cover:

- Claims received in the Great-West Healthcare Benefit Payment Office later than 15 months after date of service.
- Custodial care in a nursing home or similar setting.
- Dentures and dental care.
- Diet pills, including Meridia and Xenical, even when they are prescribed by a physician or a diet center.
- Elective abortions.
- Expenses applied toward the deductible under this plan.
- Expenses in connection with cosmetic surgery unless due to an accidental injury or to improve the function of a malformed part of the body.
- Expenses relating to the treatment of obesity including, but not limited to, gastric bypass surgery and all other related surgeries or treatments ***(and any or all complications arising therefrom)*** or any other treatment programs primarily for dieting or exercise for weight loss, including nutritional supplements, vitamins, over-the counter appetite suppressants or dietary supplements such as Dexatrim and Slim-Fast.
- Expenses or charges related to a sex change.
- Eye refractions are not covered for the purpose of medical treatment of the eyes.
- Illness for which you are covered under workers' compensation or similar program.
- Immunizations (except pneumococcal pneumonia vaccinations or immunizations required because of an injury or immediate risk of infection, and hepatitis B for certain persons at risk).
- Injury sustained while working for pay or profit.
- Nursing, speech therapy, physiotherapy or occupational therapy rendered by yourself, spouse, or a child, brother, sister or parent of yourself or spouse.
- Prescriptions not "medically necessary" such as fertility drugs and Retin A, or over-the-counter drugs such as vitamins, fluoride, etc. Also, impotence dysfunctional drugs if the required steps are not followed.
- Services and supplies incurred for routine physical examinations and tests directly related to such examinations (except some Pap smears and mammograms).
- Services and supplies incurred for vision care (i.e., exams, lenses, frames, etc.), including radial keratotomy and other procedures for conditions which can be corrected by eyeglasses or contact lenses.
- Services and supplies to the extent any benefits would be provided under Medicare for an individual protected by both Parts A and B.
- Services or supplies received as a result of an act of war (declared or undeclared) occurring while covered.
- Services or supplies received due to an injury or illness caused by or contributed to by committing or attempting to commit any crime, criminal act, assault or other felonious behavior.
- Services performed outside the U.S.
- Services provided under any government sponsored hospital or health plan.
- Services received in a government hospital unless you are required to pay for such services.
- Services to which the patient is entitled without charge, or for which there would be no charge if there were no insurance. If you are charged for services received in a non-government charitable research hospital or state hospital, this limitation will not apply.
- Smoking cessation programs, including behavior modification or other support programs; physician's office visits for smoking cessation treatment; or smoking cessation medications such as nicotine patches and gum.
- Treatment of metatarsalgia, bunions, corns, calluses, fallen arches, hammer toes, gait analysis, trimming of toenails etc., except as specified in this document.
- Treatment of (TMJ) Temporomandibular Joint Dysfunction Syndrome involving dental treatment such as bridgework, splints, appliances, braces, wires, or night guards.

Subrogation And Right Of Recovery

Another party may be liable or legally responsible for expenses incurred by a covered person for:

- An illness; or
- A sickness; or
- A bodily injury.

Other party is defined to include, but is not limited to, any of the following:

- The party or parties who caused the illness, sickness or bodily injury;
- The insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- A guarantor of the party or parties who caused the illness, sickness or bodily injury;
- The covered person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- A workers' compensation insurer;
- Any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under this plan in relation to the illness, sickness or bodily injury. When this happens, Great-West Healthcare may, at its option:

- Subrogate, that is, take over the covered person's right to receive payments from the other party. The covered person or his or her legal representative will transfer to Great-West Healthcare any rights he or she may have to take legal action arising from the illness, sickness or bodily injury to recover any sums paid under this plan on behalf of the covered person.
- Recover from the covered person or his or her legal representative any benefits paid under this plan from any payment the covered person is entitled to receive from the other party.

The covered person or his or her legal representative must cooperate fully with Great-West Healthcare in asserting its subrogation and recovery rights. The covered person or his or her legal representative will, upon request from Great-West Healthcare, provide all information and sign and return all documents necessary to exercise Great-West Healthcare's rights under this provision.

Great-West Healthcare will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the covered person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- The amount of benefits paid by Great-West Healthcare for the illness, sickness or bodily injury plus the amount of all future benefits which may become payable under this plan which result from the illness, sickness or bodily injury. Great-West Healthcare will have the right to offset or recover such future benefits from the amount received from the other party; or
- The amount recovered from the other party.

If the covered person or his or her legal representative:

- Makes any recovery from any of the sources described above; and
- Fails to reimburse Great-West Healthcare for any benefits which arise from the illness, sickness or bodily injury;
- The covered person or his or her legal representative will be personally liable to Great-West Healthcare for the amount of the benefits paid under this plan; and
- Great-West Healthcare may reduce future benefits payable under this plan for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the other party.

Great-West Healthcare's first lien rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the other party by or on behalf of the deceased employee:

- A minor covered dependent;
- The estate of any covered person; or
- On behalf of any incapacitated person.

Claims Procedures

Should it become necessary for you to present a claim for yourself or one of your covered dependents, here are a few simple procedures to follow:

Retiree's Statement

No claim may be paid without proof of loss due to an illness or injury. This proof consists of a description of the treatment or service, the date of treatment or service, the cost, the reason or diagnosis, and the name of patient. All treatments or services must be rendered or recommended by a physician licensed to practice medicine and surgery. Claims in excess of $20,000 are subject to Home Office review by Great-West Healthcare, and may take longer to process.

Providers Who Accept Medicare

When you use providers who accept Medicare, your provider may submit the required information to Medicare for you. If an assignment of benefits has not been made, Medicare will send the Explanation of Benefits and payment directly to you. In that event, forward a copy of the Explanation of Benefits, the endorsed check and a copy of your Great-West ID card to the Medicare provider. Upon receipt of this information, the provider will then forward the claim form to the Great-West Healthcare Benefit Payment Office for processing.

All Other Providers

You must first submit an itemized statement of your claim to Medicare. When you receive the Explanation of Benefits form from Medicare, please submit a copy of the Medicare Explanation of Benefits, a copy of the original itemized bill submitted to Medicare, and a completed white claim form (available from the City of Long Beach Department of Human Resources) to the Great-West Healthcare Benefit Payment Office. You must complete this form for each new illness or injury. Please be sure to answer all questions.

If you wish to have payment made directly to your physician, sign the assignment section. Leave this section blank if you desire to have payment made to you.

All forms should be forwarded to the Great-West Healthcare Benefit Payment Office listed below:

Great-West Healthcare

1000 Great-West Drive

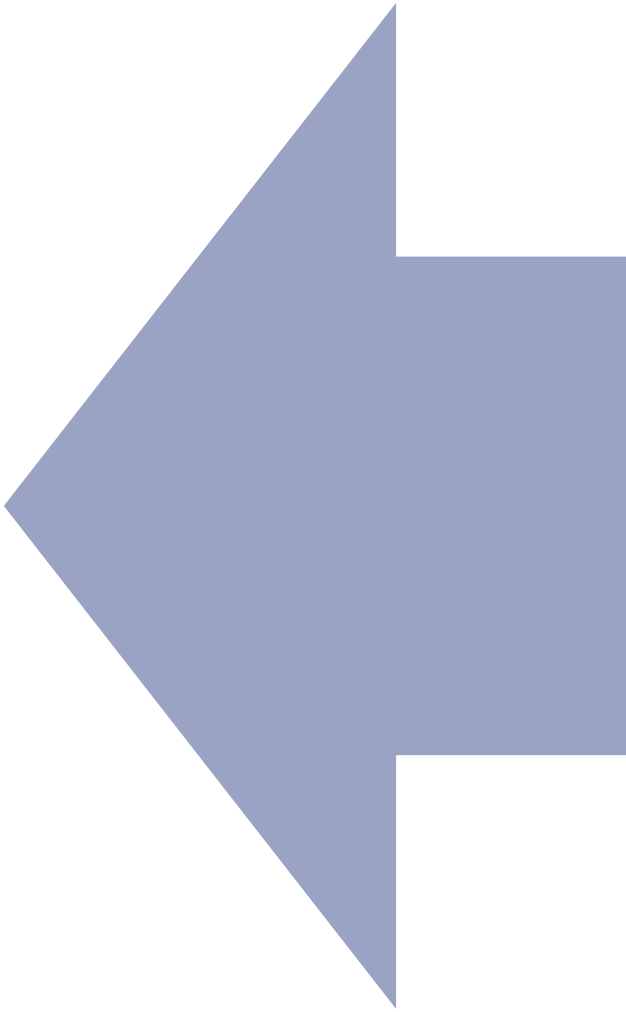
Kennett, MO 63857

Prescription Drugs

If you purchase drugs at a non-participating pharmacy, you must:

- Pay the full price of the prescription and file a claim for reimbursement
- Call the City of Long Beach Department of Human Resources for an Express Scripts prescription drug claim form
- Complete the claim form, attach your prescription drug receipt, and mail these items to the address printed on the form

Express Scripts will send the reimbursement directly to you. You will be reimbursed for the amount which would have been paid for the prescription drug had you used an Express Scripts pharmacy. If your pharmacy charges more for a prescription drug than an Express Scripts pharmacy, you will be responsible for the difference.



Explanation of Benefits

It's easy to find out how your claim has been paid by reading the Explanation of Benefits (EOB) you receive after the claim has been processed. See the examples using providers who accept Medicare (on this page) and providers who do not accept Medicare (on the following page).

When You Use Providers Who Accept Medicare

The EOB below shows:

1 Name of the provider, description of services, dates of services, and charges billed by the provider.

2 Percentage and dollar amount of the billed charges your plan covers.

3 The amount of the billed charges your plan doesn't cover. The note associated with each amount tells you if you're responsible for paying this expense.

4 Description of how we calculate the amount of your payable benefits.

Totals — Total amount your provider charged and the total allowable expenses your plan covers.

Copay and/or Deductible — Amount of the eligible charges that are covered by your copayment or applied to your deductible.

Balance — Amount remaining after we subtract the copayment or deductible from the allowable expenses.

Payable @ — Percentage at which we pay covered expenses (also at column top).

Benefit — Dollar amount payable before Coordination of Benefits.

5 C.O.B. is an abbreviation for Coordination of Benefits. Our plan shares the costs with Medicare. The amount payable by Medicare is shown in this shaded box along with the amount paid by Great-West.

6 Net Payable shows the total amount of benefits paid of eligible charges after the deductible, coverage levels and C.O.B. are calculated. If payment is made to you instead of to the provider, a check in this amount is attached.

7 Notes explains how expenses are covered (note 007).

8 This shaded box shows plan and patient identification information. Have this information at hand if you call Member Services.

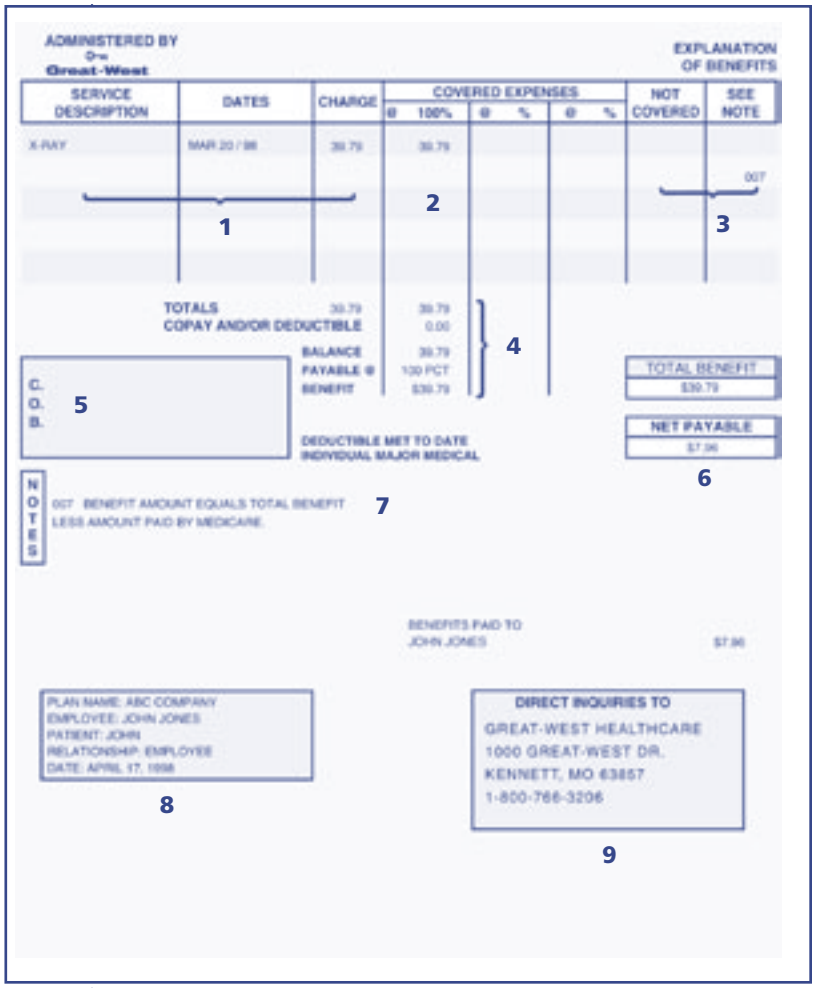
9 This is the benefit payment office to contact if you have questions. You also may make a toll-free call to Member Services using the phone number printed on your health plan ID card.

What charges do you owe?

To determine how much you're responsible for, look at your coinsurance percentage. Different services may be covered at different benefit levels, or coinsurance percentages. See the Comparison of Benefits beginning on page 9.

Still confused about a claim?

Call Member Services at the toll-free number on your ID card.



When You Use Providers Who do Not Accept Medicare

The EOB below shows:

1 Name of the provider, description of services, dates of services, and charges billed by the provider.

2 Percentage and dollar amount of the billed charges your plan covers.

3 The amount of the billed charges your plan doesn't cover. The note associated with each amount tells you if you're responsible for paying this expense.

4 Description of how we calculate the amount of your payable benefits.

Totals — Total amount your provider charged and the total allowable expenses your plan covers.

Copay and/or Deductible — Amount of the eligible charges that are covered by your copayment or applied to your deductible.

Balance — Amount remaining after we subtract the copayment or deductible from the allowable expenses.

Payable @ — Percentage at which we pay covered expenses (also at column top).

Benefit — Dollar amount payable before Coordination of Benefits.

5 Net Payable shows the total amount of benefits paid of eligible charges after the deductible, coverage levels and C.O.B. are calculated. If payment is made to you instead of to the provider, a check in this amount is attached.

6 Notes explains how certain expenses are paid a certain way, or why they aren't covered. You are responsible for expenses that aren't included among the benefits defined in your plan (note 081).

7 This shaded box shows plan and patient identification information. Have this information at hand if you call Member Services.

8 This is the benefit payment office to contact if you have questions. You also may make a toll-free call to Member Services using the phone number printed at the bottom of the EOB or the number on your health plan ID card.

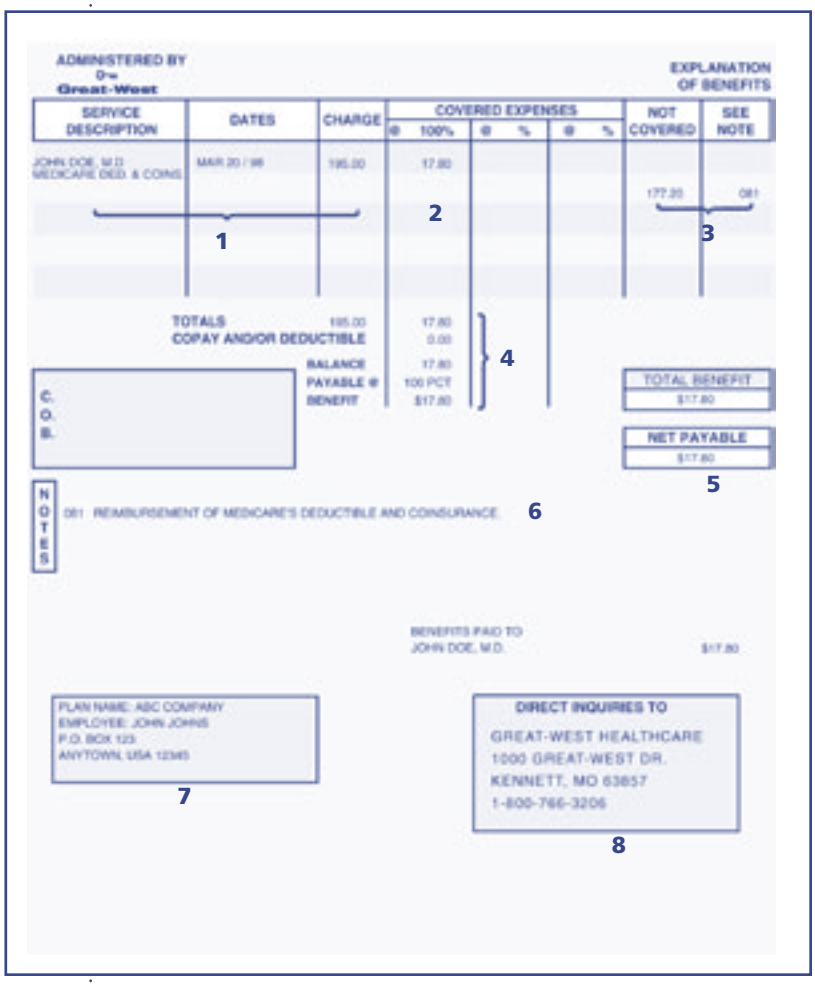
What charges do you owe?

To determine how much you're responsible for, pay attention to:

- Not covered expenses section. You may be responsible for ineligible expenses listed in the not covered column. These are expenses that aren't eligible for coverage under your plan. The note associated with any not covered charge explains why it wasn't covered, and whether or not you are responsible for paying it.

Still confused about a claim?

Call Member Services at the toll-free number on your ID card.



Communicating with Your Doctor

Here are points to consider and questions to ask to help open the lines of communication between you and your doctor. Choose the questions that apply to your situation.

Illness - Ask Your Doctor

- What is wrong? (Can you draw/show me a picture of what's wrong?)
- Can you show and explain my x-rays to me?
- How serious is this?
- What caused the problem? (Is it something I did/didn't do?)
- Can I prevent this problem from happening again? How?
- Should I see a specialist about this problem?
- Are tests needed? Which tests?
- How will the results of these tests be helpful to you?
- Are there risks associated with these tests? What risks?
- Is treatment needed? What treatment?
- Are there any treatment side-effects?
- How effective is this treatment for conditions such as mine?
- Are there any alternative treatments? What are the pros and cons of these alternatives?
- If I don't do anything about this problem, what's likely to happen?
- How will this treatment affect me physically, mentally, and emotionally?
- What effect would this treatment have on my other medical problems (e.g., high blood pressure, diabetes)?
- How long will I have to have this treatment?
- Is the treatment painful?
- What is your plan if the treatment doesn't work?
- How much of this will my insurance plan cover? What are your fees?

  (Double check with your insurance provider about extent of coverage.)
- For elective (non-emergency) surgery: "I'd like to/need to get a second opinion; how can I arrange to have a copy of my records sent to a second doctor?"

Surgery - Ask Your Doctor

- Where will the surgical incision be? How long will it be?
- How long will I have to stay in the hospital? When will I be able to return to work?
- How involved can my family be in my care?

Prescription Medicines

Ask Your Doctor

- What is this medicine for? How will it help me?
- What are the side effects of this medicine? If they occur, what should I do?

Which should I report to you?

- Can I increase or decrease the dosage on my own, or should I call you first for advice?
- Will this medicine make me sleepy?
- Are there any other medicines (prescription or non-prescription) that should not be taken while I'm taking this medicine?
- Are there any foods I should avoid while taking this medicine?
- Can I smoke or drink alcoholic beverages while taking this medication?
- Can I stop taking this medicine early if the symptoms disappear?
- How soon should I expect to feel better?
- Are you prescribing tablets, capsules, or a liquid? (Tell the doctor if you have difficulty swallowing large tablets, don't like cherry-liquids, etc.)
- For tablets, is it OK if I crush the tablet and mix it with food?
- Should I call you when the medicine is gone?
- Can you prescribe a generic (instead of a brand name) form of this medicine in this case?

Ask Your Pharmacist

- What time of day should I take this medicine?
- Should I take before meals, with meals, after meals?
- When you say I should take this medicine every (4) hours, does that mean I have to wake up at night to take it?
- Can I take this pill with milk? Water? Orange juice?
- What should I do if I forget one dose? Two doses?
- Remember to ask for a child-resistant or easy-off top; aids for remembering when to take pills.

Index